Group Short Term Disability Insurance Benefits

WESTPOINT STEVENS

Greater Georgia Life

An Independent Licensee of the
Blue Cross and Blue Shield Association

EXHIBIT
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This booklet-certificate is not a policy contract or a part of the Group Policy. It merely describes in general terms the benefits provided by the group policy which is on file in the office of your employer and may be inspected there.

GREATER GEORGIA LIFE INSURANCE COMPANY
Home Office: Atlanta, Georgia

Form No. VGSTD98-C (6/98)

GENERAL INFORMATION

This booklet-certificate describes the benefits provided by the group policy as of December 1, 2004. Your Certificate Schedule on page 6 identifies your amount of coverage.

DEFINITIONS

"We", "our", and "us" refer to Greater Georgia Life Insurance Company. We may use "he", "his" or "him" to refer to an insured person, male or female.

"Active" means you are performing the normal duties of your regular occupation for the Employer at your normal place of employment. You are considered active on regular paid vacation days or regular scheduled days off if you are not disabled and were active on your last regular scheduled working day. An Employee is deemed Active on each day he is on an Employer approved leave of absence with short term disability benefits.

"Employee" means a person working for the Employer on a regular full-time hourly basis for twenty (20) hours or more per week and who is compensated by the Employer for such work.

An "insured person" means you, provided enrollment requirements have been met and all due premiums have been paid.

"Totally Disabled" or "Total Disability" means that you: (1) are unable, due to a disability (whether Illness or Injury), to perform all of the duties of your regular occupation, supported by objective medical evidence; (2) are under the regular care and attendance of a physician, appropriate for the condition causing the disability; and (3) are not otherwise employed for wage or profit.

WHO IS AN ELIGIBLE EMPLOYEE

If you are a regular full-time hourly employee working at least 20 hours per week, you are eligible for insurance upon completion of the waiting period required by your employer provided that the group policy provides benefits for your Employee Classification.

WHEN INSURANCE BEGINS

Your insurance becomes effective on December 1st, 2004 if you are Active and eligible on that date. Otherwise, your insurance will be deferred until the day following the date you become Active.

WHEN INCREASES OR DECREASES IN AMOUNTS OF INSURANCE ARE EFFECTIVE

Increases in your coverage become effective on the premium due date following the date a change in coverage occurs, with certain provisions. You must be active on the date any increase in insurance is to become effective. Otherwise, your increase will become effective on the day following the date you become active. If evidence of insurability is required for the increase, the date the increase becomes effective will be subject to our approval of the evidence. We must receive notice of a change from the Employer within 31 days after it occurs. Decreases in amounts of insurance occur on the premium due date following the date of the change.

WHEN INSURANCE TERMINATES

Your insurance will end on the date below which occurs first:

- the date the Group Policy ends;
- the date you end your employment or cease to be "Active" due to certain leaves of absence (as determined by your Employer), or because of injury or illness;
- the date you cease to meet the definition of "insured person";
- the date your Class is deleted from the group policy or you cease to be eligible under any Class;

Supplemental Plan only:

- the date you stop making a contribution, if contributions are required;

If the Group Policy terminates while you are receiving or are eligible to receive benefits under this policy, benefits will be paid for that disability as though the Group Policy had not terminated.

REINSTATEMENT AFTER TEMPORARY ABSENCE

You may be eligible to have your insurance reinstated if your insurance terminates because of a temporary absence resulting from your not being Active as a regular full-time hourly employee. Reinstatement means that you will not be required to furnish evidence of insurability, but you are required to notify the Human Resource Office if you wish to reinstate your Supplemental Coverage, and you must complete an Enrollment form to restart your Supplemental Coverage and premium deductions. We will reinstate your terminated insurance on the date you complete one full day of Active work after a temporary absence, provided:

BASIC PLAN:

1. The temporary absence is due solely to:

   - Your Employer granting you an authorized leave of absence without Short Term Disability benefits;
   - Temporary lay off;
   - A leave of absence that is in compliance with the Family Medical Leave Act; or
   - Being called to active duty as a reservist with the U.S. Armed Forces Reserve;

2. You return to work and become Active as a regular full-time hourly employee of the Employer and are under an eligible Class; and

3. If the absence was due to Injury or Illness, the return must be made within 12 months after the insurance terminated (except in the case of an absence due to an Injury or Illness for which You are entitled to benefits under any worker's compensation or similar law, in which case, the 12 month limit does not apply), or, if earlier, on the first date You return to work following the Injury or Illness.

SUPPLEMENTAL PLAN:

1. The temporary absence is due solely to:

   - Your Employer granting you an authorized leave of absence without Short Term Disability benefits;
   - Temporary lay off;
   - A leave of absence that is in compliance with the Family Medical Leave Act; or
   - Being called to active duty as a reservist with the U.S. Armed Forces Reserve;

2. You return to work and become Active as a regular full-time hourly employee of the Employer and are under an eligible Class;

3. If the absence was due to Injury or Illness, the return must be made within 12 months after the insurance terminated (except in the case of an absence due to an Injury or Illness for which You are entitled to benefits under any worker's compensation or similar law, in which case, the 12 month limit does not apply), or, if earlier, on the first date You return to work following the Injury or Illness; and

4. If during an authorized leave of absence, you fail to pay the premium, you must complete the 3-month eligibility requirement upon returning to work. If you are out on Total Disability and exceed the Maximum Benefit Period, you are eligible on the date you return to work. During any period that exceeds the Maximum Benefit Period, no premium is due.

CERTIFICATE SCHEDULE OF INSURANCE

DISABILITY INCOME BENEFIT:

Amount, or amounts, of benefits available to any Employee shall be determined in accordance with the classes described below:

BASIC PLAN:

CLASS	BASIC PLAN BENEFIT	DAY BENEFITS BEGIN INJURY	DAY BENEFITS BEGIN ILLNESS	MAX BENEFIT PERIOD INJURY	MAX BENEFIT PERIOD ILLNESS
All Regular Full-time Hourly Active Employees	$ 60/week	1st Day*	8th Day	26 Weeks	26 Weeks

SUPPLEMENTAL PLAN: (You may opt to elect additional coverage based upon the following:)

Bracket	Base Annual Earnings Minimum	Base Annual Earnings Maximum	Supplemental Benefit
1	$0	$12,750	$70/week
2	$12,751	$15,000	$90/week
3	$15,001	$17,000	$110/week
4	$17,001	$19,250	$130/week
5	$19,251	$21,500	$150/week
6	$21,501	$23,750	$170/week
7	$23,751	$26,000	$190/week
8	$26,001	Over	$210/week

DAY BENEFITS BEGIN INJURY	DAY BENEFITS BEGIN ILLNESS	MAX BENEFIT PERIOD INJURY	MAX BENEFIT PERIOD ILLNESS
1st Day*	8th Day	26 Weeks	26 Weeks

*If you suffer an accident (a sudden and unexpected event requiring treatment by a physician), benefits will be payable as of the date you first receive medical care as a result of the accident.

Pregnancy Benefits (normal pregnancy, childbirth or elective abortion): Included

ELIGIBILITY DATES

BASIC PLAN:

Eligible on the date that is 3 months after the date of employment.

SUPPLEMENTAL PLAN:

Eligible on the date that is 3 months after the date of employment. An Employee must enroll on or before the 31st day following the date the Employee becomes eligible in order to avoid having to submit evidence of insurability.

OFFSETS AND EXCLUSIONS

OFFSETS

The amount of benefit will be reduced by the following

1. The amount of any disability income benefits for which you are eligible under any compulsory benefit act or law.
2. The amount of disability income benefits for which you are eligible under:
   - any other group insurance plan of the Policyholder;
   - any governmental retirement system as a result of your employment with the Employer.
3. The amount of disability benefits for which you are eligible under the United States Social Security Act, or any similar plan or act.
4. The amount you receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).
5. The amount of similar benefits you receive under the mandatory portion of any "no fault" motor vehicle plan.

EXCLUSIONS

We will not pay benefits for any period of disability that is a result of:

1. Injury or Illness for which you are entitled to benefits under any worker's compensation or similar law;
2. Injury which arises out of, or is caused, or contributed to by, any employment or occupation for pay or profit;
3. Intentional self-inflicted injury, whether sane or insane;
4. War, declared or not, including any act of aggression or resistance to aggression by any country or combination of countries, whether or not You are in military service;
5. Injury sustained while You are in military service for any country at war;
6. Injury sustained while committing, or attempting to commit, a felony; resisting or fleeing from arrest; or being engaged in illegal activities; or
7. Being under the influence of alcohol (unless registered in an Employer approved treatment/rehabilitation center); voluntarily taking, inhaling, or absorbing into the body any hallucinogen, narcotic, or other drug (unless prescribed for you by a physician); voluntarily inhaling gas or fumes or voluntarily taking poison.

BENEFIT PAYMENTS

Your employer has the necessary instructions and can assist in filing a claim (Proof of Loss) for benefits. Notice of claim must be given to us within thirty days after the loss begins, or as soon as reasonably possible. All benefits will be paid to you. Any unpaid benefits due at your death will be paid to your Estate.

For Claims Service, please call or write to:

GREATER GEORGIA LIFE INSURANCE CO.
Disability Service Center
P.O. BOX 723058
ATLANTA, GEORGIA 31139
1-800-232-0113

Claims Process

1. To file a claim, call 1-800-232-0113.
2. A claims service representative will ask you for information that will be needed to process your claim.
3. A Disability Case Manager will contact your physician for the medical information needed to process your claim.
4. A claims package will be mailed to your home address. This package will include several forms which you will need to complete and return to Greater Georgia Life (GGL) at the address shown above. The forms contained in this package are very important and must be returned to GGL promptly or your claim review could be delayed.
5. GGL will contact your Human Resources Department to confirm your job title, work status, and the physical demands of your job.
6. You will be notified when a decision has been reached regarding your claim.

SUMMARY PLAN DESCRIPTION INFORMATION

The Name of the Plan is:
The Short Term Disability Option of The WestPoint Stevens Inc. Welfare Benefits Plan

Plan Administrator and Agent for Service of Legal Process is:
WestPoint Stevens Inc.
P.O. Box 71
507 W. Tenth Street
West Point, GA 31833
(706) 645-4000

The Employer Identification Number is: 36-3498354

The Plan Number is 504.

Benefits under this Plan are provided through insurance in accordance with the terms and conditions of the group contract issued by the Claims Administrator and Claims fiduciary who is Greater Georgia Life Insurance Company. Greater Georgia Life Insurance Company is the Claims Administrator and "appropriate named fiduciary" of the Plan for purpose of reviewing denied claims under the Plan. In exercising such fiduciary responsibility and as the claims fiduciary, Greater Georgia Life Insurance Company will have discretionary authority to determine entitlement to Plan benefits for each claim received and to construe the terms of the Plan.

You must be eligible in order to be entitled to benefits under the Plan. The eligibility requirement of the Plan and the benefits You are insured for are explained in detail in this booklet.

The Plan Administrator is responsible for the administration of the Plan and is the designated agent for the service of legal process for the Plan. Functions performed by the Plan Administrator include: the receipt and deposit of any required contributions, maintenance of records of Plan participants, authorization and payment of Plan administrative expenses, selection of insurance consultants and the selection of the insurance carrier.

The Plan Year begins on January 1st.

CLAIMING BENEFITS

You or your representative must initiate a claim to receive any benefits or to take any other action under the Plan. Please see the claims filing information identified in the BENEFITS PAYMENT section on page 8, herein.

Appealing a Denied Claim

If an application for disability benefits is denied in whole or in part, you or your representative will receive written or electronic notification from the Claims Administrator, within 45 days after your claim is received. This period may be extended by the Plan for up to 30 days (with the possibility of an additional 30 days, for a total extension period of 60 days), provided the Claims Administrator determines that such extensions are necessary due to matters beyond the control of the Plan and notifies you or your representative prior to the expiration of the initial 45-day period (and prior to the expiration of the initial 30-day extension period for the additional 30-day extension period) of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision (in which case you will be notified in writing). In the case of any extension, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded 45 days within which to provide the specified information.

The notice of denial will include:

- the reasons for the denial with reference to the specific Plan provisions on which the denial was based,
- a description of any additional information needed to perfect the claim and an explanation of why such information is necessary,
- a description of the Plan's claim review procedures and applicable time limits, and
- a statement of your right to bring civil action under ERISA Section 502 (a) following an adverse benefit determination on review,
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided to you free of charge upon request, and
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances or a statement that such an explanation will be provided to you free of charge upon request.

Within 180 days after receiving the denial, you or your representative may submit a written request for reconsideration of the claim to the Claims Administrator. Any such request should be accompanied by documents, records, or other information in support of the appeal. You or your representative may have reasonable access to, and copies of, all documents, records and other information relevant to the claim free of charge. The review that will be provided will not afford deference to the initial decision to deny your claim and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial denial, nor the subordinate of such individual.

In deciding an appeal of any denial that is based in whole or in part on a medical judgment, the appropriate named fiduciary shall consult with a health care professional, whose identification must be provided, and who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is not the individual that was consulted in connection

with the initial denial of the claim nor a subordinate of any such individual. A failure to request a review of a denied claim within the time frame specified above will be treated as full and complete agreement with the denial.

The Claims Administrator will respond within 45 days of the appeal, or 90 days under special circumstances (in which case you will be notified in writing of the extension, of the reasons for the extension, and the date the review of the appeal is expected to conclude). In its response to the appeal, the Claims Administrator will explain, in writing or electronically:

- the reasons for the decision, again with reference to the specific Plan provisions on which that decision is based,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to pertinent documents, records, and other information relevant to your claim for benefits,
- a description of the Plan's voluntary appeal procedures, and
- your right to bring an action under ERISA Section 502 (a) for claims denied on review. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided free of charge to you upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation or statement of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances will be provided to you free of charge upon request.

The Claims Administrator has the right to interpret the provisions of the Plan and its decision will be conclusive and binding. Benefits under the Plan are payable only if and to the extent the Claims Administrator determines they are properly payable under the Plan. If a decision on review is not furnished within the specified time period, your claim will be deemed denied on review.

Be advised: You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Plan Termination and Amendment

Your Employer expects and intends to continue the Plan, but reserves its right to terminate the Plan, in whole or in part, without notice. Your Employer also reserves its right to amend the Plan at any time.

Your Employer may also increase or decrease its contributions or the participants' contributions to the Plan.

If the Plan is terminated while you are an employee of the Employer, you will not have any further rights other than the payment of benefits for covered losses or expenses incurred before the Plan is terminated. The amount and form of any final benefit you or your beneficiary receives will depend on any contract provisions affecting the Plan and Your Employer's decisions.

The Plan of insurance will terminate at the earliest occurrence of the following events:

1. When the Employer delivers or mails to the Insurer a written notice requesting termination; or
2. 31 days following the Policyholder's failure to make a premium payment; or
3. When The Insurer elects not to renew the contract.

STATEMENT OF ERISA RIGHTS

(as required by Federal law and regulation)

As a participant in this Group Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan administrator's office and at other locations, such as work sites and union halls, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration, such as annual reports and Plan descriptions.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan administrator. The administrator may make a reasonable charge for the copies.

3. Receive a summary of the plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the employee benefit plan. These persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of the Plan participants and they must exercise prudence in the performance of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the plan.

Your employer may not fire You or discriminate against You to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA. If Your claim for welfare benefits is denied, in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan administrator and do not receive them within 30-days, You may file suit in a federal court. In such case, the court may require the Plan administrator to provide You the materials and pay You up to $110 a day until You receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan administrator.

If Your claim for benefits is denied or ignored, in whole or in part, You may file suit in a state or federal court. If plan fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. If You are successful, the court may order the person You have sued to pay these costs and fees. If you lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous. If you have any questions about Your Plan, You should contact the Plan administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Welfare Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Welfare Security, Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.